Washington State Department of Health

Facilities and Services Licensing
Investigations

Complaint Form

Mail Form and Information to:

Department of Health
Facilities and Services Licensing/Investigations
PO BOX 47852
Olympia, WA 98504-7852
Hotline: (800) 633-6828

Please provide as much information as you can on this form. This will help avoid delays in processing your complaint. Thank you.

<table>
<tr><td colspan="2">Facility Name</td><td>Facility Phone</td><td>Facility Unit (Room #)</td></tr>
<tr><td colspan="2">Facility Address</td><td>City</td><td>State & Zip Code</td></tr>
<tr><td colspan="2">Complainant Name</td><td colspan="2">Relationship to Patient/Resident</td></tr>
<tr><td colspan="2">Address</td><td rowspan="2">Voice Phone
( )</td><td rowspan="2">2nd Voice Phone
( )</td></tr>
<tr><td>City</td><td>State & Zip Code</td></tr>
<tr><td colspan="2">Patient/Resident Name</td><td>Voice Phone
( )</td><td>2nd Voice Phone
( )</td></tr>
<tr><td colspan="2">Address</td><td rowspan="2">Patient DOB
/ /</td><td rowspan="2">Patient Diagnosis</td></tr>
<tr><td>City</td><td>State & Zip Code</td></tr>
<tr><td>Today's Date
/ /</td><td>Admission Date
/ /</td><td>Discharge Date
/ /</td><td>Incident(s) Date(s)</td></tr>
<tr><td colspan="4">Please describe your specific complaint in the space below. Be as specific as possible. Please provide any supporting documentation. You may attach additional sheets if necessary. You will be informed of any action taken by this office.</td></tr>
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Why do you believe the incident occurred?
How was the patient affected by the incident?
What prompted your call now:

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Investigations

Did you contact the facility? Yes ☐ No ☐
Facility response:
Participants: Please include the names of other patients/resident/ witnesses/staff members involved:
Name: Title: Phone #:
Address:
Name: Title: Phone #:
Address:
Name: Title: Phone #:
Address:
Name: Title: Phone #:
Address:
Expected Outcome (What do you expect to happen as a result of this investigation?):